

## VOLUNTARY MEDICAL HISTORY

LOCATION:	DATE:
CHILD'S FIRST NAME:	DATE OF BIRTH:
MALE: <input type="checkbox"/> FEMALE: <input type="checkbox"/>	TIME OF BIRTH <input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> AFRICIAN-AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> BI-RACIAL <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER	

### ABOUT THE PREGNANCY

WHILE PREGNANT, DID YOU HAVE ANY OF THE FOLLOWING  
CONDITIONS AND/OR WERE YOU EXPOSED TO ANY OF THE FOLLOWING:  
(PLEASE CHECK THE AREA THAT APPLIES TO YOU)

<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> VISUAL DISTURBANCES	<input type="checkbox"/> MENINGITIS
<input type="checkbox"/> CHLAMYDIA	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> MUMPS
<input type="checkbox"/> DIABETES (HIGH SUGAR)	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> MEASLES
<input type="checkbox"/> DOMESTIC VIOLENCE	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> X-RAY/RADIATION
<input type="checkbox"/> HAZARDOUS CHEMICALS	<input type="checkbox"/> INFECTIONS	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> HEAD ACHES/SEIZURES	<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE/VEENERAL DISEASE	
<input type="checkbox"/> OTHER: _____		

DID YOU TAKE ANY OF THE FOLLOWING DURING YOUR PREGNANCY?  
CHECK ONLY THOSE THAT APPLY.

<input type="checkbox"/> ALCOHOL (BEER, WINE, LIQUOR, ETC.)	<input type="checkbox"/> CRACK	<input type="checkbox"/> METHADONE
<input type="checkbox"/> AMPHETAMINES (UPPERS)	<input type="checkbox"/> ECSTASY	<input type="checkbox"/> LSD/ACID
<input type="checkbox"/> BARBITURATES (DOWNERS)	<input type="checkbox"/> HEROIN	<input type="checkbox"/> COCAINE
<input type="checkbox"/> CAFFEINE (COFFEE, SODA, ETC.)	<input type="checkbox"/> INHALANTS ("HUFFING")	<input type="checkbox"/> TOBACCO PRODUCTS
<input type="checkbox"/> IV DRUG USE	<input type="checkbox"/> MARIJUANA	<input type="checkbox"/> OTHER _____

### FAMILY HEALTH HISTORY

CHECK IF ANY APPLY TO THE BIRTH FATHER, BIRTH MOTHER, OR EXTENDED FAMILY  
(E.G. AUNT, UNCLE, SISTER, BROTHER, COUSIN, GRANDPARENT, ETC.)

<input type="checkbox"/> ALLERGIES      TYPE: _____	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> PROBLEMS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> SCHIZOPHRENIA
<input type="checkbox"/> ARTHRITIS/JOINT PROBLEMS	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> SCOLIOSIS (SPINAL CURVATURE)
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEMOPHILIA/BLEEDING	<input type="checkbox"/> SICKLE CELL ANEMIA
<input type="checkbox"/> ATTENTION DEFICIT/HYPER ACTIVITY	<input type="checkbox"/> HUNTINGTON'S DISEASE	<input type="checkbox"/> SKIN PROBLEMS (PSORIASIS, ECZEMA,)
<input type="checkbox"/> BLINDNESS/VISUAL PROBLEMS		<input type="checkbox"/> SPEECH PROBLEMS
<input type="checkbox"/> CANCER(S)      TYPE _____	<input type="checkbox"/> HYPERTENSION (HIGH BLOOD PRESSURE)	
<input type="checkbox"/> CEREBRAL PALSY	<input type="checkbox"/> KIDNEY PROBLEMS	
<input type="checkbox"/> CYSTIC FIBROSIS	<input type="checkbox"/> LEARNING DISABILITIES	<input type="checkbox"/> SPINA BIFIDA (BORN WITH OPEN SPINE)
<input type="checkbox"/> DEAF/HEARING PROBLEMS	<input type="checkbox"/> MENTAL RETARDATION	<input type="checkbox"/> STROKE
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> MULTIPLE SCLEROSIS	<input type="checkbox"/> TAYLOR'S DISEASE
<input type="checkbox"/> DIABETES (HIGH SUGAR)	<input type="checkbox"/> MUSCULAR DYSTROPHY	<input type="checkbox"/> THYROID DISORDER
<input type="checkbox"/> DOWNS SYNDROME	<input type="checkbox"/> NERVOUS BREAKDOWN	
<input type="checkbox"/> OTHER: _____		

WAS THE BABY BORN: <input type="checkbox"/> HOME <input type="checkbox"/> AT THE HOSPITAL	OTHER (PLEASE EXPLAIN)
WAS THE BABY PREMATURE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MANY WEEKS PREMATURE?
DID YOU RECEIVE PRENATAL CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID YOU TAKE PRESCRIBED MEDICATION(S) DURING YOUR PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, WHAT?	

THIS FORM IS BEING PROVIDED TO YOU IN ORDER TO OBTAIN MEDICAL INFORMATION ABOUT THE NEWBORN. THIS FORM MAY BE FULLY OR PARTIALLY COMPLETED, AND MAY BE COMPLETED AT THE SAME TIME AS DELIVERING THE NEWBORN OR AT A LATER DATE. THIS FORM IS COMPLETELY VOLUNTARY, AND NO LEGAL CONSEQUENCES WILL RESULT FROM FAILURE TO COMPLETE ANY PART OF THIS FORM.